and time dependent variables. Patient characteristics are age, gender, severity, being prone to side effects and the potential to be dangerous. Variables changing in time are outpatient visits, being in a psychotic episode, symptom score, treatment, compliance, having side effects and treatment location. Dependencies are taken into account. Costs are calculated guided by visits, medication and location. Outcomes are expressed in terms of the number and duration of psychotic episodes and the cumulative PANSS-score. Information on treatment alternatives, transition probabilities, model structure and health care utilisation was derived from literature and an expert panel. **RESULTS:** It is estimated that first-line treatment with long-acting risperidone is economically dominant over the alternatives. Per 1000 patients, it is estimated to prevent approximately 200 and 410 relapses in five years compared to scenario 1 and 3. Correspondingly, it is estimated to save €15,115 and €6,972 per patient. Sensitivity analyses show that the conclusion of economic dominance is very robust. **CONCLUSION:** Long-acting risperidone combines additional effectiveness with cost savings in patients with a high probability of being non-compliant, and should be preferred first-line treatment over oral atypicals and conventional depots.

PMH6

DIRECT MEDICAL COSTS FOR TREATMENT OF PATIENTS EXPERIENCING BIPOLAR DISORDER EPISODES IN THE UK

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OBJECTIVE: To estimate resource use and direct medical costs associated with treatment of Bipolar I Disorder (BPDI) and Bipolar II Disorder (BPDII) episodes in the UK. **METHODS:** A retrospective chart review was conducted covering 19 months of observations on a sample of 134 UK patients aged 18 years or over (average age 48.4 years) diagnosed with Bipolar Disorder. **RESULTS:** Patients with BPDI experienced an average of 1.11 episodes per year whilst BPDII patients experienced 1.21 episodes per year. The yearly average direct cost for patients who experienced at least one episode during the study period was £7,714 for BPDI patients (n = 68) and £2,980 for BPDII patients (n = 25). There were 103 hospitalisations during the study period and these hospitalisations formed the major component of the total treatment costs with a yearly average hospitalisation cost of £6,280 for BPDI patients and £1,636 for BPDII patients. The average yearly drug cost for BPDI patients was found to be £383 (5% of total cost) and £194 (6.5% of total cost) for BPDII patients. Manic Episodes required twice as many hospitalisations per episode and were associated with a longer length of stay in hospital compared with Depressive Episodes. The average length of stay in hospital was 65 days for Manic, 46 days for Mixed and 36 days for Depressive Episodes. The average hospital cost was found to be £7,015 for a Manic Episode, £4,574 for a Mixed Episode and £3,787 for a Depressive Episode. **CONCLUSIONS:** The average treatment cost of a BPDI patient was found to be more than twice the cost of a BPDII patient. The cost difference is driven by the finding that Manic Episodes required more hospitalisations and were associated with a longer length of hospital stay compared with Mixed or Depressive Episodes.

PMH7

BOTTOM-UP OR TOP-DOWN? IMPACT OF PATIENT SELECTION ON COST-OF-ILLNESS RESULTS

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OBJECTIVES: Currently in the Netherlands a randomised clinical trial is executed to compare two outpatient psychotherapies for patients with Borderline Personality Disorder (BPD). The goal of the present study was to calculate the cost-of-illness (COI) of BPD for Dutch Society. **METHODS:** We used a prevalence-based approach, which takes into account total yearly costs of all patients who are diagnosed with BPD at a certain point in time. COI was calculated both top-down and bottom-up. For top-down calculation, prevalence figures from existing registrations and costs of the Dutch health care system from government publications were used. Baseline cost interviews of 88 BPD-patients in the trial were used to estimate bottom-up COI. BPD was defined according to ICD-9 and ICD-10 (top-down) and DSM-IV (bottom-up) classifications. **RESULTS:** Based on literature, prevalence of BPD in the Dutch general population was estimated at 1.1%. For all cost items, large differences arise between the bottom-up and the top-down approach. Total yearly societal are €200,184,828 top-down, and 16 times as high €3,258,240,100 for bottom-up. Healthcare costs represent 0.03% and 1.03% of total Dutch health care expenditure, respectively. **CONCLUSION:** Our results show large differences between the two methods. The top-down figure probably is an underestimation of true costs due to incomplete registrations. On the other hand, the bottom-up patient group may not be representative of the Dutch BPD population because of the in-en exclusion criteria used in the trial, which exclude the very mild and the very severe cases. In conclusion, we recommend to assess COI and prevalence in a combined design. First, prevalence in the general population is assessed. Subsequently, those subjects diagnosed with the disease under study should be followed, receiving care as usual, in order to determine COI. This is the only way to match bottom-up patient group and total population.